NEWBORN MEDICAID CERTIFICATION

(TEMPORARY)

Please use ink and press firmly.

Mail white copy of completed form to:

GHP
Box 5000
McRae, GA 31055

NEWBORN MEDICAID I.D. NO.

Certifying provider must contact GHP to obtain a newborn I.D.

VALID ONLY:

From (DOB) ___/___/___

Thru ___/___/___

NEWBORN'S NAME _____ (*First*) _____ (*MI*) _____ (*Last*) _____ (*Suffix*)

DATE OF BIRTH _____ **SEX** ☐ *Male* ☐ *Female*

MOTHER'S NAME _____ (*First*) _____ (*MI*) _____ (*Last*)

U.S. CITIZEN? ☐ *Yes* ☐ *No*

_____ (*Mother's **Medicaid** I.D. No.*) _____ (*Mother's **Social Security No.***)

MAILING ADDRESS _____ (*Number and Street*)

_____ (*City*) _____ (*State*) _____ (*ZIP*)

_____ (*County*) ( ) _____ (*(Area Code) Telephone*)

DATE OF REQUEST ___/___/___ **PARENT / RELATIVE SIGNATURE** _____

COMPLETED BY _____ (*Please Print*) **TITLE** _____

PROVIDER NAME _____ (*Please Print*) **TELEPHONE** ( )

DATE COMPLETED ___/___/___

PROVIDER SIGNATURE _____ **PROVIDER NO.** _____

By signing, I certify to the best of my knowledge that the information above is verified and accurate.

Please contact GHP to verify the mother's Medicaid eligibility for the month of the newborn's birth, and to obtain the newborn's Medicaid I.D. number.

White copy **GHP**
Pink copy **Client**
Yellow copy **Pharmacy**
Blue copy **Certifying Provider**

DMA-550